1. Overview of Coding

Contents

1.1 About the Revenue Operations Manual

The Indian Health Service *Revenue Operations Manual* provides a system-wide reference resource for all Indian, Tribal, and Urban (I/T/U) facilities across the United States, to assist any and all staff with any function related to business operation procedures and processes.

1.1.1 Revenue Operations Manual Objectives

- Provide standardized policies, procedures, and guidelines for the Business Office related functions of IHS facilities.
- Capture accurate coding for all procedures and services to maximize reimbursement for each facility.
- Provide on-line, via the IHS Intranet, reference material subdivided by department and function that is accessible to all facilities.
- Share innovative concepts and creative approaches to Business Office functions across all the Area offices and facilities.
- Promote a more collaborative internal working environment throughout all of IHS.
- Foster and promote continuous quality improvement standards, which when implemented and monitored on a day-to-day basis, will ensure the highest quality of service at each level of the Business Office operation.

1.1.2 Revenue Operations Manual Contents

The *Revenue Operations Manual* is divided into the following five (5) parts:

- **Part 1 Administrative Roles and Responsibilities** contains
  - Overview of revenue operations
  - Laws, acts, and regulations affecting health care
  - IHS laws, regulations, and policies
  - Health Insurance Portability and Accountability Act Privacy Rule
  - Business Office management and staff
  - Business Office Quality Process Improvement and Compliance
- **Part 2 Patient Registration** contains:
  - Overview of patient registration
  - Patient eligibility, rights, and grievances
  - Direct care and contract health services
  - Third-party coverage

  - Registration, discharge, and transfer
  - Scheduling appointments
  - Benefit coordinator

- **Part 3Coding** contains:
  - Overview of coding
  - Medical record documentation
  - Coding guidelines
  - Data entry

- **Part 4 Billing** contains:
  - Overview of billing
  - Hard copy vs. electronic claims processing
  - Billing Medicare, Medicaid, and private insurance
  - Third party liability billing
  - Billing private dental insurance and Pharmacy
  - Secondary billing process

- **Part 5 Accounts Management** contains:
  - Overview of accounts management
  - Electronic deposits and Remittance Advices
  - Processing zero pays, payments, and adjustments
  - Creating payment batches
  - Reconciliation of credit/negative balances
  - Collections and collection strategies
  - Rejections and appeals

Each part and chapter of the manual is designed to address a specific area, department, or function. A part may also contain one or more appendices of topic-related reference materials.

This manual also includes:

- Acronym dictionary
- Glossary

1.1.3 Accessing the Revenue Operations Manual

The *Revenue Operations Manual* is available for downloading, viewing, and printing at this website:

http://www.ihs.gov/NonMedicalPrograms/BusinessOffice/index.cfm

Clicking the "Revenue Operations Manual (ROM)" option on the left panel menu, displays the Revenue Operations Manual web page.

1.2 About Coding

Coding, as defined by the **American Health Information Management Association (AHIMA)** is the transformation of verbal descriptions of diseases, injuries, and procedures into numeric or alphanumeric designations.

Originally, medical coding was performed to classify mortality (cause of death) data on death certificates. However, coding is also used to classify morbidity and procedural data. The coding of health-related data permits access to medical records by diagnoses and procedures for use in clinical care, research, and education.

Since the implementation of the Federal government's payment system in 1983, there has been greater emphasis placed on medical coding. Currently, reimbursement of hospital and physician claims for Medicare patients depends entirely on the assignment of codes to describe the diagnoses, services, and procedures provided.

In the 1990s the Federal government attached the problem of healthcare fraud and abuse. As the basis for reimbursement, appropriate medical coding has become crucial as healthcare providers seek to assure compliance with official coding guidelines.

There are many demands for accurately coded data from the medical record. In addition to their use on claims for reimbursement, codes are included on data sets used to evaluate healthcare processes and outcomes. Coded data are also used internally by institutions for quality management activities, case-mix management, planning, marketing, and other administrative and research activities.

Coding is taking the written documentation of the provider and communicating that documentation into the most appropriate, accurate coding that accurately reflects what the provider has done during the clinic visit.

The provider is the person who can most accurately convert the written documentation. As the provider codes, potential discrepancies between what he/she documented and what he/she actually performed during the visit, and the coding structure will become apparent, allowing the provider either to more accurately document his/her notes or to adjust the coding to coincide with the documentation.

Coding is critical to a successful outcome with the insurer. Without correct coding, reimbursement may be comprised and/or claims rejected.

Golden Rule of Coding – "*If it is not documented, it is not billable*."

For more information, go to these websites:

- American Medical Association Coding Guidelines, available at http://www.ama-assn.org/
- ICD-9-CM Official Guidelines for Coding and Reporting, available at http://www.cdc.gov/nchs/about/otheract/icd9/abticd9.htm

1.3 National Correct Coding Initiative

The **Centers for Medicare and Medicaid Services (CMS)** developed the **National Correct Coding Initiative (NCCI)** to

- promote national correct coding methodologies
- control improper coding that leads to inappropriate payment in Part B claims

The coding policies are based on coding conventions defined in the American Medical Association's **Current Procedural Terminology (CPT)** manual, national, and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practice and review of correct coding practice.

The NCCI edits identical pairs of services that normally should not be billed by the same physician for the same patient on the same day. The NCCI includes two types of edits:

- **Comprehensive/Component edits** – identifies code pairs that should not be billed together because one service inherently includes the other.
- **Mutually Exclusive edits** – identifies code pairs that, for clinical reasons, are unlikely to be performed on the same patient on the same day. For example, a mutually exclusive edit might identify two different types of testing that yield equivalent results.

The NCCI edits are updated quarterly and are available at this website: http://www.cms.hhs.gov/NationalCorrectCodInitEd/

1.3.1 Ethics for a Medical Coder

"The professional medical coder has a duty to code medical services and procedures to the best of his or her ability. It is imperative that the coder know his or her limitations and asks for help from the provider or a more experienced coder when in doubt. No one knows everything there is to know about coding, as the rules and the codes combined with the regulatory errata change on an almost daily basis. The important point is that the coder knows where to look for the information needed. The American Medical Association (AMA), national specialty medical societies, and local carriers can all serve to provide important information. It is more important to get the correct answer than to portray false knowledge."

– American Medical Association

1.4 Standards of Ethical Coding

A goal for all coders is to code accurate clinical and statistical data. The following standards of ethical coding, developed by American Health Information Management Association's (AHIMA) Coding Policy and Strategy Committee should be used as a reference guide.

- Coding professionals are expected to support the importance of accurate, complete, and consistent coding practices for the production of quality health care data.
- Coding professionals in all health care settings should adhere to the ICD-9-CM coding conventions, official coding guidelines and rules established by the American Medical Association, and any other official coding rules and guidelines established for use with mandated standard code sets. Selection and sequencing of diagnoses and procedures must meet the definitions of required data sets for applicable health care settings.
- Coding professionals should use their skills, their knowledge of currently mandated coding and classification systems, and official resources to select the appropriate diagnostic and procedural codes.
- Coding professional should only assign and report codes that are clearly and consistently supported by physician documentation in the health record.
- Coding professionals should consult physicians for clarifications and additional documentation prior to code assignment when there is conflicting or ambiguous data in the health record.

- Coding professionals should not change codes or the narratives of codes in the billing abstract so that meanings are misrepresented. Diagnoses or procedures should not be inappropriately included or excluded because payment or insurance policy coverage requirements will be affected.

  When individual payer policies conflict with official coding rules and guidelines, obtain these policies in writing whenever possible. Reasonable efforts should be made to educate the payee on proper coding practices in order to influence a change in the payer's policy.

- Coding professionals, as members of the health care team, should assist and educate physicians and other clinicians by advocating proper documentation practices, further specificity, and re-sequencing or inclusions of diagnoses or procedures when needed, to more accurately reflect the acuity, severity, and the occurrence of events.
- Coding professionals should participate in the development of institutional coding policies and should ensure that coding policies complement, not conflict with, official coding rules and guidelines.
- Coding professionals should maintain and continually enhance their coding skills, as they have a professional responsibility to stay abreast of changes in codes, coding guidelines, and regulations.
- Coding professionals should strive for optimal payment to which the facility is legally entitled, remembering that it is unethical and illegal to optimize payment by means that contradict regulatory guidelines.